Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOHN B KRAJCA RADCLIFFE MD
10109 MCKKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name
TECHNOLOGY INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-12-2374-01

MFDR Date Received

March 15, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was denied in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $2,250.00 for this claim but were paid nothing. The explanation given on the EOB justifying the denial states: *THE PROCEDURES CODE IS INONISSTENT WITH THE MOFIFIER USED OR A REQURIED MODIFIER IS MISSING,* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32.

Therefore, please issue a payment promptly in the amount of $2,250.00 to settle this claim."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response received

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 02, 2011	CPT Code 99456-W5-WP	$150.00	$150.00
	CPT Code 99456-W8-RE	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 effective May 25, 2008, sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 effective May 25, 2008, sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 17, 2011

   - 16 – Not all info needed for adjudication was supplied
   - 4 – Required modifier missing or inconsistent w/ proceed
   - W5 – DD exam with IR or MMI
   - WP – Whole procedure back/spine is 1 area only. 1 MMI eval allowed regardless of body areas. Per report, claimant is not @ MMI: submit with the correct modifier for not @ MMI & the DWC 32 form

   Explanation of benefits dated November 22, 2011

   - 16 – Not all info needed for adjudication was supplied
   - 4 – Required modifier missing or inconsistent w/proceed
   - W5 – DD exam with IR or MMI
   - WP – Whole procedure back/spine is 1 area only. 1 MMI eval allowed regardless of number of body areas. Per report, claimant is not @ MMI: submit with the correct modifier for not @ MMI & the DWC32 form
   - 150 – Payment adjusted/unsupported service level

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-WP in the amount of $600.00 for one unit and 99456-W8-RE in the amount of $500.00 for one unit.

   Review of DWC-32 and DWC 69 form support a request for Designated Doctor Examination was requested to address Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW).

   Per 28 Texas Administrative Code §134.204 states "(4) The following applies for billing and reimbursement of an IR evaluation, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used."

   Therefore, CPT Code 99456-W5-WP is supported for Impairment Rating (IR) evaluation for 1 body area using Diagnosis Related Estimate (DRE).

   The total MAR is $150.00

   Per 28 Texas Administrative Code states "(i) The following shall apply to Designated Doctor Examinations, (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   Therefore, CPT Code 99456-W8-RE is supported for Return to Work (RTW) examination.

   The total MAR is $500.00

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $650.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/4/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.